# TOPICAL AGENT PRIOR AUTHORIZATION REQUEST FORM


*OptumRx*
**P.O. Box 25184**
**Santa Ana, CA, 92799**
**Phone: (800) 310-6826  Fax: (866) 940-7328**


Optum Rx®

United Healthcare Community Plan

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

**Note:** This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

| | |
|---|---|
| Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐ | Date of Birth ☐☐ / ☐☐ / ☐☐☐☐ |
| Patient's Name | Prescriber's Name |
| Prescriber's IN License # ☐☐☐☐☐☐☐☐ | Specialty |
| Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐ | Prescriber's Signature |
| Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐ | Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐ |
| Check box if requesting retro-active PA ☐ | Date(s) of service requested for retro-active eligibility (if applicable): |

*Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).*

| Requested Medication | Strength | Quantity | Dosage Regimen | Diagnosis |
|---|---|---|---|---|
| | | | | |

**PA Requirements:**

1. What is the prescriber's specialty? _____
2. Have any other providers been consulted in the prescribing of the requested agent? ☐ Yes ☐ No
   If yes, please provide the other provider's specialty: _____
3. Has the member tried and failed any other medication(s) for the requested diagnosis? ☐ Yes ☐ No
   If yes, please provide drug/dose/date(s) of use:

| Drug(s) and Dose | Dates of Use |
|---|---|
| | |

4. Provide medical justification for use at requested dose and duration:

**Additional Drug-Specific Questions:** **(Not required if not applicable)**

**Topical NSAIDs:**

1. Are oral medications unsuitable for member use? □ Yes □ No
   If yes, faxed prescriber documentation (e.g., medical chart record) is required to be attached.